		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0021436

Facility Name: Lewis Memorial Christian Village

Address: 3400 West Washington (Number) Springfield (City) 62707 (Zip Code)

County: Sangamon

Telephone Number: 217-787-9600 **Fax #** 217-787-9601

IDPA ID Number: 51-0173104001

Date of Initial License for Current Owners: 9/77

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501©3			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: William O. Buskirk **Telephone Number:** 217-525-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1, 2001 to June 30, 2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Mark Havrilka

(Title) Chief Financial Officer

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) William O. Buskirk, CPA

(Firm Name & Address) Eck, Schafer & Punke, LLP, 600 East Adams Springfield, IL 62701-1624

(Telephone) 217-525-1111 Fax # 217-525-1120

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	76	Skilled (SNF)	76	27,740	1
2		Skilled Pediatric (SNF/PED)			2
3	79	Intermediate (ICF)	79	28,835	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	155	TOTALS	155	56,575	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,654	14,759		27,413	8
9	SNF/PED					9
10	ICF	11,851	14,510		26,361	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,505	29,269		53,774	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.05%

D. How many bed-hold days during this year were paid by Public Aid?
226 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 09/19/1977

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary None

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 06/30/2002 Fiscal Year: 06/30/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	260,958	28,169	9,756	298,883		298,883		298,883			1
2	Food Purchase		271,279		271,279		271,279	(3,019)	268,260			2
3	Housekeeping	170,386	17,938		188,324		188,324		188,324			3
4	Laundry	71,246	14,027		85,273		85,273	(750)	84,523			4
5	Heat and Other Utilities			133,072	133,072		133,072	4,368	137,440			5
6	Maintenance	102,513	19,024	49,472	171,009		171,009	7,364	178,373			6
7	Other (specify):*											7
8	**TOTAL General Services**	605,103	350,437	192,300	1,147,840		1,147,840	7,963	1,155,803			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	2,254,520	98,202	20,955	2,373,677		2,373,677		2,373,677			10
10a	Therapy			16,948	16,948		16,948		16,948			10a
11	Activities	37,128			37,128		37,128		37,128			11
12	Social Services	107,467	4,746	8,192	120,405		120,405	(2,367)	118,038			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,399,115	102,948	46,095	2,548,158		2,548,158	(2,367)	2,545,791			16
	C. General Administration											
17	Administrative	130,188	2,467	240,636	373,291		373,291	(183,346)	189,945			17
18	Directors Fees											18
19	Professional Services			4,244	4,244		4,244	13,805	18,049			19
20	Dues, Fees, Subscriptions & Promotions			21,196	21,196		21,196	375	21,571			20
21	Clerical & General Office Expenses	72,629	7,180	69,924	149,733		149,733	6,454	156,187			21
22	Employee Benefits & Payroll Taxes			506,318	506,318		506,318	22,464	528,782			22
23	Inservice Training & Education			4,711	4,711		4,711		4,711			23
24	Travel and Seminar			7,679	7,679	190	7,869	6,409	14,278			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			63,943	63,943		63,943	2,681	66,624			26
27	Other (specify):*											27
28	**TOTAL General Administration**	202,817	9,647	918,651	1,131,115	190	1,131,305	(131,158)	1,000,147			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,207,035	463,032	1,157,046	4,827,113	190	4,827,303	(125,562)	4,701,741			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Lewis Memorial Christian Village #0021436 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			161,419	161,419		161,419	12,381	173,800			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			138,785	138,785		138,785	(81,271)	57,514			32
33	Real Estate Taxes			1,089	1,089		1,089		1,089			33
34	Rent-Facility & Grounds							(1,285)	(1,285)			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*			481	481		481	6,621	7,102			36
37	**TOTAL Ownership**			301,774	301,774		301,774	(63,554)	238,220			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops	31,606	2,609	190	34,405	(190)	34,215		34,215			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			84,863	84,863		84,863		84,863			42
43	Other (specify):* Apt/Congregate			849,332	849,332		849,332	(34,238)	815,094			43
44	**TOTAL Special Cost Centers**	31,606	2,609	934,385	968,600	(190)	968,410	(34,238)	934,172			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,238,641	465,641	2,393,205	6,097,487		6,097,487	(223,354)	5,874,133			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,019)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space	(1,285)	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients	(750)	4		8
9	Non-Straightline Depreciation	3,521	30		9
10	Interest and Other Investment Income	(97,706)	32		10
11	Discounts, Allowances, Rebates & Refunds	(439)	21		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(34,238)	43		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(59,554)	21		24
25	Fund Raising, Advertising and Promotional	375	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Page 5A	16,313			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (176,782)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(46,572)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (46,572)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (223,354)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Lewis Memorial Christian Village

ID# 0021436

Report Period Beginning: July 1, 2001

Ending: June 30, 2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vending	$ (2,367)	12	1
2	Activity	746	21	2
3	Marketing Expense	(5,122)	17	3
4	PY Deferred Bond Expense	16,435	32	4
5	Loss on Equipment Disposal	8,182	36	5
6	Gain on Sale of Investment	(525)	36	6
7	Miscellaneous Income	(1,036)	36	7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	16,313		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(3,019)	0	0	0	0	0	0	0	0	0	0	(3,019)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(750)	0	0	0	0	0	0	0	0	0	0	(750)	4
5	Heat and Other Utilities	0	4,368	0	0	0	0	0	0	0	0	0	4,368	5
6	Maintenance	0	7,364	0	0	0	0	0	0	0	0	0	7,364	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,769)	11,732	0	0	0	0	0	0	0	0	0	7,963	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	(2,367)	0	0	0	0	0	0	0	0	0	0	(2,367)	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(2,367)	0	0	0	0	0	0	0	0	0	0	(2,367)	16
	C. General Administration													
17	Administrative	(5,122)	(178,224)	0	0	0	0	0	0	0	0	0	(183,346)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	13,805	0	0	0	0	0	0	0	0	0	13,805	19
20	Fees, Subscriptions & Promotions	375	0	0	0	0	0	0	0	0	0	0	375	20
21	Clerical & General Office Expenses	(59,247)	65,701	0	0	0	0	0	0	0	0	0	6,454	21
22	Employee Benefits & Payroll Taxes	0	22,464	0	0	0	0	0	0	0	0	0	22,464	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	6,409	0	0	0	0	0	0	0	0	0	6,409	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	2,681	0	0	0	0	0	0	0	0	0	2,681	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(63,994)	(67,164)	0	0	0	0	0	0	0	0	0	(131,158)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(70,130)	(55,432)	0	0	0	0	0	0	0	0	0	(125,562)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Lewis Memorial Christian Village **#** 0021436 **Report Period Beginning:** July 1, 2001 **Ending:** June 30, 2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	3,521	8,860	0	0	0	0	0	0	0	0	0	12,381	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(81,271)	0	0	0	0	0	0	0	0	0	0	(81,271)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	(1,285)	0	0	0	0	0	0	0	0	0	0	(1,285)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	6,621	0	0	0	0	0	0	0	0	0	0	6,621	36
37	**TOTAL Ownership**	(72,414)	8,860	0	0	0	0	0	0	0	0	0	(63,554)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(34,238)	0	0	0	0	0	0	0	0	0	0	(34,238)	43
44	**TOTAL Special Cost Centers**	(34,238)	0	0	0	0	0	0	0	0	0	0	(34,238)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(176,782)	(46,572)	0	0	0	0	0	0	0	0	0	(223,354)	45

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached Schedule						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Christian Homes Inc.	100.00%	$ 4,368	$ 4,368	1
2	V	6	Maintenance				7,364	7,364	2
3	V	17	Administrative	240,636			62,412	(178,224)	3
4	V	18	Directors						4
5	V	19	Professional Services				13,805	13,805	5
6	V	20	Fees, Subscriptions						6
7	V	21	Clerical				65,701	65,701	7
8	V	22	Employee Benefits				22,464	22,464	8
9	V	23	Inservice Training						9
10	V	24	Travel & Seminar				6,409	6,409	10
11	V	26	Insurance				2,681	2,681	11
12	V	30	Depreciation				8,860	8,860	12
13	V								13
14	Total			$ 240,636			$ 194,064	$ * (46,572)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This workpaper is not applicable.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2001 Ending: ne 30, 2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		This workpaper is not applicable.				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Reilly Mortgage		x	Building & Equipment	$16,828.19	05/01/76	$ 2,557,200	$	09/01/18	0.0750	$ 108,127	1
2	CIB Mortgage		x	Refinance Bldg & Equip	$12,266.00	05/01/02	1,920,000	1,914,404	04/01/07	0.0583	28,229	2
3	Amort of financing fee		x	Refinance							1,980	3
4	Bond fund	x									449	4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$29,094.19		$ 4,477,200	$ 1,914,404			$ 138,785	9
	B. Non-Facility Related*											
10	Bond fund											10
11	Revenue Bonds 1991-C		x	Redeem Debt	$5,580.94	07/01/91	658,000		07/01/11	0.0775	9,301	11
12	Revenue Bonds 2001-Y		x	Refinance	$2,771.00	10/01/01	475,000	475,000	10/01/31	0.0792	24,937	12
13												13
14	TOTAL Non-Facility Related				$8,351.94		$ 1,133,000	$ 475,000			$ 34,238	14
15	TOTALS (line 9+line14)						$ 5,610,200	$ 2,389,404			$ 173,023	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 **Report Period Beginning:** July 1, 2001 **Ending:** June 30, 2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$ #VALUE!	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ #VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1997	8
	1998	9
	1999	10
	2000	11
	2001	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Lewis Memorial Christian Village COUNTY Sangamon

FACILITY IDPH LICENSE NUMBER 0021436

CONTACT PERSON REGARDING THIS REPORT Brenda Lavin

TELEPHONE 217-732-9651 FAX #: 217-732-8686

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	See Attached List		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 55,000 B. General Construction Type: Exterior Masonry Frame Steel Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Apartments
Congregagte
Home Office

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: None
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	217,800	Various	$ 308,762	1
2	Home Office			8,567	2
3	TOTALS	217,800		$ 317,329	3

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	155			1977	$ 2,286,830	$ 56,166	40	$ 57,171	$ 1,005	$ 1,394,735	4
5				1978	100,542		40	2,514	2,514		5
6				1979	420,937		20				6
7											7
8	Home Office Allocation				61,258	1,794		1,794		30,132	8
	Improvement Type**										
9	Bldg Improvement			1979	306	6	38	8	2	138	9
10	Bldg Improvement			1981	4,662	155	30	155		3,230	10
11	Heating/Cooling Systems			1981	20,153	329	20	329		20,153	11
12	Exhaust Fan			1983	417		15			417	12
13	Door Assembly			1985	1,244	62	20	62		1,054	13
14	Bldg Improvement			1986	573	29	20	29		469	14
15	Pass-thru WD			1986	664	33	20	33		514	15
16	Remodeling			1987	800	40	20	40		613	16
17	Rooftop Compressor			1988	3,408		10			3,408	17
18	Air System			1989	1,090	55	20	55		738	18
19	A/C Unit			1989	4,406		8			4,406	19
20	Remodeling			1989	6,193	310	20	310		4,133	20
21	Tile, Cover Base			1989	6,600		5			6,600	21
22	Wall Paper			1989	826		5			826	22
23											23
24	Cabinets			1990	100	3	15	3		100	24
25	Roof Top A/C Unit			1991	4,158		10			4,158	25
26	Command Moduole			1991	1,318		5			1,318	26
27	Wall Paper/Carpet			1991	14,848		5			14,848	27
28	Drapery Hardware			1991	1,124		5			1,124	28
29	Carpeting			1992	640		5			640	29
30	Curtain Track			1992	523		5			523	30
31	Curtain Track			1992	4,124		5			4,124	31
32	Receptacle			1992	575	34	10	34		575	32
33	Curtain Track			1992	565		5			565	33
34	Curtain Track			1992	1,229		5			1,229	34
35	Door Control			1993	722	48	15	48		456	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Nurse Station Remodel	1993	$ 30,556	$ 1,528	20	$ 1,528	$	$ 13,385	37
38	Wallcoverings	1993	751		5			751	38
39									39
40	Wallcoverings	1994	3,747		5			3,747	40
41	A/C Compressors	1994	1,506	151	10	151		1,346	41
42	Exhaust Fans	1994	2,183	146	15	146		1,302	42
43	Roof Entire Building	1993	125,670	8,378	15	8,378		72,369	43
44	Downspout Repairs	1994	6,000	400	15	400		3,400	44
45	Ceiling Tile	1994	1,149	115	10	115		968	45
46	Wallpaper/Floor Covering	1994	20,655		5			20,655	46
47	Lounge Remodel	1995	14,653		5			14,653	47
48	Volunteer Room Expansion	1995	8,435	843	10	843		5,235	48
49	Remodel Wing 100	1995	44,657	3,679	10	3,679		39,373	49
50	Remodel Shower Wing	1995	24,272	2,302	5	2,302		17,939	50
51	Wallcovering	1995	35,194		5			35,194	51
52	Stainless Steel Floor Cooler	1996	1,873		5			1,873	52
53	Wanderguard Alzheimer	1996	10,455	1,046	10	1,046		6,373	53
54	Wallcovering	1996	3,910		5			3,910	54
55	Wallcovering	1996	22,106	369	5	369		22,106	55
56	Gas Meter & Lines	1997	7,378	982	5	982		7,378	56
57	Maglocks & Keypad	1997	7,194	719	10	719		3,835	57
58	Nurse Call System	1997	9,727	973	10	973		5,186	58
59	Wallcovering	1997	28,134	5,627	5	5,627		27,949	59
60	Exhaust Fan	1997	12,370	1,237	10	1,237		6,082	60
61	Upgro Energy Management System	1997	14,513	1,451	10	1,451		7,134	61
62	Upgro Antennae System	1997	2,400	480	5	480		2,320	62
63									63
64	Hot Water Heater	1997	21,388		10			21,388	64
65	Wallcovering	1997	6,836	1,367	5	1,367		6,265	65
66	Fire Safety Gas Valve	1998	617	123	5	123		554	66
67	Locks	1998	782	156	5	156		689	67
68	Wiring for Network	1998	625	125	5	125		531	68
69	Outlets for Kronos	1998	664	133	5	133		499	69
70	TOTAL (lines 4 thru 69)		$ 3,421,235	$ 91,394		$ 94,915	$ 3,521	$ 1,855,615	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,421,235	$ 91,394		$ 94,915	$ 3,521	$ 1,855,615	1
2	Entrance Canopy	1998	3,667	733	5	733		2,627	2
3	Fire Alarm Control Panel	1998	28,154	2,815	10	2,815		10,087	3
4	Repl Fire Alarm Device	1999	4,800	480	10	480		1,640	4
5	Kitchen Hood	1999	6,910	691	10	691		2,303	5
6	Fire Alarm Devices	1999	4,600	460	10	460		1,533	6
7	Replace 8 Shower Valves	2000	10,084	2,017	5	2,017		5,715	7
8	Panduit Raceway	2000	13,130	1,313	10	1,313		3,611	8
9	Kitchen Ceiling	2000	5,923	592	10	592		1,381	9
10	Kitchen Walls	2000	2,099	210	10	210		438	10
11	CARPET #207	2000	1,344	269	5	269		516	11
12	WATER HEATERS	2001	37,299	3,730	10	3,730		4,973	12
13	NATURAL GAS REGULATOR	2001	1,184	118	10	118		157	13
14	40 GALLON WATER HEATER	2001	506	51	10	51		55	14
15	Remodel Shower-Wing 200	1/21/2002	3,500	175	10	175		175	15
16	(2) Horton Single Swing Security Door	3/28/2002	4,094	91	15	91		91	16
17	Rooftop A/C-Heat Unit	1/15/2002	3,762	126	15	126		126	17
18	Carpet Installation-TV Lounge & 2 Dways	5/30/2002	1,787	60	5	60		60	18
19	Heating/AC Unit	4/15/2002	1,348	23	15	23		23	19
20	Replacement of Heat/AC Unit Pump	4/30/2002	1,449	24	15	24		24	20
21	Less: Disposals		(1,249)					(1,249)	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,555,626	$ 105,372		$ 108,893	$ 3,521	$ 1,889,901	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 430,232	$ 50,533	$ 50,533	$	Various	$ 227,512	71
72	Current Year Purchases	77,230	5,462	5,462		Various	5,462	72
73	Fully Depreciated Assets	416,538				Various	416,538	73
74	Home Office Allocation	93,149	4,035	4,035		Various	50,614	74
75	TOTALS	$ 1,017,149	$ 60,030	$ 60,030	$		$ 700,126	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transportation	1989 Ford Bus	1989	$ 38,359	$	$	$	5	$ 38,359	76
77	Patient Transportation	1993 Chevy Pickup/w Blade	1998	13,290	1,846	1,846		5	13,290	77
78										78
79	Home Office Allocation			10,975	3,031	3,031			7,673	79
80	TOTALS			$ 62,624	$ 4,877	$ 4,877	$		$ 59,322	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,952,728	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 170,279	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 173,800	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 3,521	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,649,349	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Apartment, Carport, & Equipment	$ 488,859	$ 9,905	$ 297,260	86
87	Duplex Bldg & Land Improvement	4,352,424	149,152	1,324,449	87
88	Duplex Equipment	136,258	6,364	107,092	88
89	Congregate Bldg & Land Improvements	4,052,866	99,850	1,023,134	89
90	Congregate Equipment	118,667	6,363	94,848	90
91	TOTALS	$ 9,149,074	$ 271,634	$ 2,846,783	91

G. Construction-in-Progress

	Description	Cost	
92	Construction in Progress	$ 15,478	92
93			93
94			94
95		$ 15,478	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: This Workpaper is not applicable.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ ____ Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	This	hrs							2
3	Licensed Recreational Therapist	Workpaper	hrs							3
4	Licensed Physical Therapist	is not	hrs							4
5	Physician Care	Applicable.	visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of June 30, 2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,283,805	$	1
2	Cash-Patient Deposits	14,249		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 71,092)	525,385		3
4	Supply Inventory (priced at FIFO)	21,586		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Other A/R & Accrued Int Rec	22,363		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,867,388	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	308,762		13
14	Buildings, at Historical Cost	11,356,529		14
15	Leasehold Improvements, at Historical Cost	704,667		15
16	Equipment, at Historical Cost	1,249,137		16
17	Accumulated Depreciation (book methods)	(5,407,713)		17
18	Deferred Charges	47,575		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	1,955,710		21
22	Other Long-Term Assets (spe CIP	15,478		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 10,230,145	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 12,097,533	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 46,972	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	14,249		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	271,694		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	87,987		32
33	Accrued Interest Payable	9,293		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 430,195	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,914,404		40
41	Bonds Payable	475,000		41
42	Deferred Compensation	1,600,517		42
	Other Long-Term Liabilities(specify):			
43	Due Apt. Residents	2,094,943		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 6,084,864	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 6,515,059	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 5,582,474	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 12,097,533	$	48

***(See instructions.)**

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 5,690,498	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 5,690,498	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	468,415	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) PY Deferred Bond Expense	(16,435)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 451,980	17
	B. Transfers (Itemize):		
18	Transfer Out to Affiliate	(560,004)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (560,004)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 5,582,474	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,534,337	1
2	Discounts and Allowances for all Levels	(1,091,070)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,443,267	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,621	12
13	Barber and Beauty Care	33,165	13
14	Non-Patient Meals	3,019	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,475	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 39,280	23
	D. Non-Operating Revenue		
24	Contributions	104,520	24
25	Interest and Other Investment Income***	127,834	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 232,354	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Unrealized G(L) on Equipment Sold/Investments	(4,539)	28
28a	Residential & Congregate	855,540	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 851,001	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,565,902	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,147,840	31
32	Health Care	2,548,158	32
33	General Administration	1,131,115	33
	B. Capital Expense		
34	Ownership	301,774	34
	C. Ancillary Expense		
35	Special Cost Centers	883,737	35
36	Provider Participation Fee	84,863	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,097,487	40
41	**Income before Income Taxes (line 30 minus line 40)****	468,415	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 468,415	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,819	1,967	$ 53,482	$ 27.19	1
2	Assistant Director of Nursing	1,685	1,796	39,970	22.26	2
3	Registered Nurses	9,586	10,251	242,771	23.68	3
4	Licensed Practical Nurses	31,560	32,802	587,212	17.90	4
5	Nurse Aides & Orderlies	107,199	110,512	1,268,587	11.48	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,797	5,960	62,498	10.49	8
9	Activity Director					9
10	Activity Assistants	3,656	3,809	37,128	9.75	10
11	Social Service Workers	10,088	10,532	107,467	10.20	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	1,785	1,892	28,705	15.17	14
15	Cook Helpers/Assistants	22,797	23,664	232,253	9.81	15
16	Dishwashers					16
17	Maintenance Workers	7,276	7,537	102,513	13.60	17
18	Housekeepers	16,609	16,996	170,386	10.03	18
19	Laundry	6,566	6,896	71,246	10.33	19
20	Administrator	3,058	3,480	130,188	37.41	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager	1,931	2,045	29,052	14.21	23
24	Clerical	4,520	4,698	43,577	9.28	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Beauty Shop	2,074	2,197	31,606	14.39	33
34	TOTAL (lines 1 - 33)	238,006	247,034	$ 3,238,641 *	$ 13.11	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	201	$ 9,756	1.3	35
36	Medical Director	12	1,510	10.3	36
37	Medical Records Consultant	36	2,700	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	120	2,200	10A.3	39
40	Physical Therapy Consultant	192	11,516	10A.3	40
41	Occupational Therapy Consultant	39	3,078	10A.3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	39	2,354	10A.3	43
44	Activity Consultant				44
45	Social Service Consultant	99	8,119	12.3	45
46	Other(specify) Dental Consultant	11	1,300	10A.3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	749	$ 42,533		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Robert Florence	Administrator	0	$ 130,188
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 130,188

B. Administrative - Other

Description	Amount
Management Expense	$ 240,636
TOTAL (agree to Schedule V, line 17, col. 3)	$ 240,636
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Van Ostrand	Legal	$ 713
Davis & Campbell	Legal	1,538
FR & R Healthcare Consulting	Medicare Consulting	898
Booth, Little & Antoline	Legal	40
Lewis, Hockey & Brown	Survey	75
Brown, Hay & Stephens	Legal	429
Dan Royer	Audit	551
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 4,244

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 91,432
Unemployment Compensation Insurance	14,256
FICA Taxes	238,899
Employee Health Insurance	144,550
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Expense	11,833
Employee Physicals	5,348
Home Office Allocation	22,464
TOTAL (agree to Schedule V, line 22, col.8)	$ 528,782

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	5,126
Health Care Worker Background Check	
(Indicate # of checks performed)	
IHCA Dues	8,785
American Health Care Assoc	765
Internet & Media Fees	151
Software Upgrades & Support	4,725
Subscriptions dues & licences	1,644
Home office allocation	375
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 21,571

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 234
In-State Travel	2,315
Seminar Expense	3,160
Other seminar expense	2,160
Home Office Allocation	6,409
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,278

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	This workpaper is not applicable.		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Lewis Memorial Christian Village # 0021436 Report Period Beginning: July 1, 2001 Ending: June 30, 200

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA - $8,785**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? _____

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5-10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **31,095** Line **10.2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **84,863**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **3,019**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **0**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **No**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **0**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Eck, Schafer & Punke LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Will mail when completed.**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Lewis Memorial Christian Village
Summary of Employee Benefits and Taxes

kdb
10/24/02

Payroll Tax	Unemploy Contrib	Workers Comp	Health Insurance	Benefit Percent	Employment Expense	Physicals	Med Exp	W.C.
165,998.55	9,528.00	61,188.00	109,200.00	81,248.70				
20,332.74	1,404.00	9,012.00	4,550.00	7,104.07				
13,928.90	948.00	6,096.00	350.00	5,685.13				629,471.53
4,166.57	480.00	3,048.00	4,200.00	3,041.98				
7,386.63	456.00	2,904.00	4,200.00	5,821.50				
9,941.49	684.00	4,428.00	11,200.00	4,740.17				
14,833.50	600.00	3,876.00	6,650.00	13,968.09	11,832.60	5,348.00		
2,312.14	156.00	1,020.00	4,200.00	1,542.77			-140.00	
238,900.52	14,256.00	91,572.00	144,550.00	123,152.41	11,832.60	5,348.00	-140.00	629,471.53

Less: Benefits	-123,152.41
	506,319.12

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	123,152.41
Congregate	4,106.58
	127,258.99